## **Rejection Sensitivity Treatment Plan**

Patient information				
Name:		Age:		
Gender:		Plan start date:		
Rejection sensitivity history				
Current symptoms:		Duration/onset:		
History of rejection sensitivity:				
Treatment goals				
Short-term goals:		Long-term goals:		
Treatment interventions				
Intervention	Focus area/s	Description	Remarks	

Coping strategies		
Coping strategy	Description/instructions	Remarks
Medications		
Additional notes		
Healthcare professional:	Signatu	re: